PENNSYLVANIA ACADEMY OF FAMILY PHYSICIANS

HOUSE BILL 2849: THE MEDICAL NECESSITY ACT
DEVELOPMENT OF AN OBJECTIVE, UNIFORM DEFINITION

TO: **Honorable Members of The Judiciary Committee of the Pennsylvania House of Representatives**

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The Pennsylvania Academy of Family Physicians ("PAFP") assisted in the drafting of House Bill 2849 and supports this legislation. This testimony is presented to provide the Committee with public policy and legal rationale substantiating the enactment of HB 2849.

The Problem - Insurer Arbitrariness

- PAFP's physician members report numerous circumstances where all types of third party payors deny reimbursement for medical care, contending services were "not medically necessary".

- If the insurance company action is appropriate, it cuts payors' expenses. If inappropriate, it still cuts payor costs, but wrongly jeopardizes a patient's access to medical services, shifts costs to patients and/or providers, and increases costs by adding paperwork and hassle to an already overburdened health care delivery system.

- Governor Ridge and the General Assembly have made a positive and concerted effort to create a pro-business environment in Pennsylvania, including decreasing the "unnecessary hassles" for conducting business in the Commonwealth.

- PAFP's 4,200 members include over 2,400 both small and mid-size health care businesses that should not have to endure arbitrary and "unnecessary hassles" in treating their patients. The approximately 9,000 total physician practices (including all specialties) in the Commonwealth merit the same pro-business support while treating Pennsylvania consumers.

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- Because the linchpin of payment for and access to health care is "medical necessity", an objective, uniform definition of that term is crucial.

- Nevertheless, no objective definition of the term "medical necessity" exists under Pennsylvania law.

- The definition of "medical necessity" changes literally depending on who is making the determination and the kind of insurance plan or coverage.

- Reasonable and medically necessary care is consistently denied by insurance companies regardless of the payor system involved.

- Typically, the cost to litigate a breach of contract action against an insurance company to collect payment for medically necessary treatment exceeds the value of the claim.

- PAFP contends insurance companies generate substantial profits by denying medically necessary care, knowing that the vast majority of physicians will not litigate or undertake the "hassle" to collect on a viable, medically necessary service.

Existing Pennsylvania Law

- As noted above, no objective statutory definition of "medical necessity" exists under Pennsylvania law.

- The Motor Vehicle Financial Responsibility Law (pursuant to the amendments by Act 6 of 1990) defines the term as follows:

  "'Necessary medical treatment and rehabilitative services.' Treatment, accommodations, products or services which are determined to be necessary by a licensed health care provider **unless they shall have been found or determined to be unnecessary by a state-approved Peer Review Organization ("PRO").**" 75 Pa.C.S. § 1702.

- Therefore, under auto insurance, medical care is necessary unless a PRO says it isn't. This definition is merely circuitous, and provides no objective measurement.

- The Health Maintenance Organization Act contains no definition of the term. The HMO regulations promulgated by the Insurance Department define the term as follows:

  "Medical necessity or medically necessary - Appropriate and necessary services **as determined by the HMO** which are rendered to a member for a condition requiring, according to generally accepted principles of good medical practice, the diagnosis or direct care and treatment of an illness or injury and which are not provided only as a convenience." 31 Pa. Code § 301.2.

- Again, no objectivity exists in the definition; it simply vests unfettered, absolute discretion in HMO medical directors to make determinations of medically necessity.

- The Pennsylvania Superior Court issued a landmark decision on July 1, 1996 that negatively affects due process and contract rights of physicians and other health care providers relating to Pennsylvania Blue Shield decisions denying reimbursement for treatment or services Blue Shield considers not medically necessary.

  In Rudolph v. Pennsylvania Blue Shield, __ Pa. Superior Ct. __, 679 A.2d 805 (1996), the Superior Court held that a physician does not have the right to *de novo* review of a Blue Shield Medical Review Committee determination in a trial court. In other words, a health care provider cannot file a breach of contract suit against Blue Shield in court and have a judge or jury render an independent analysis of the facts and law. A health care provider is essentially limited to filing an appeal in court from an unfavorable Medical Review Committee decision, but only if the provider can plead and prove allegations that fraud or misconduct occurred in the Medical Review Committee proceeding. Accordingly, under this decision, Blue Shield could perpetrate an unconscionable bad faith medical necessity denial, conduct the Medical Review Committee hearing in compliance with the limited requirements contained in the Blue Shield Bylaws, and be insulated from judicial review.

  In its rationale, the Superior Court concluded that the Blue Shield statute, provider contract (referred to as "regulations" by Blue Shield), and Bylaws for participating providers "clearly contemplate finality in the [Medical Review] Committee decision". The Court reasoned that the legislature created a "constitutionally adequate method" in the MRC hearing procedures because physicians are given notice of the reimbursement denial (based upon lack of medical necessity and a hearing). Unfortunately, the Court clearly ignored the fundamental due process requirement of **fairness** in any hearing. In particular, the Court ignored the fact that the MRC members are **appointed and hand selected by the Chairman of the Board of Pennsylvania Blue Shield**. The members of the MRC, therefore, are clearly not impartial nor are they disinterested in the outcome of the decision. As the dissenting opinion noted, this situation is a "**flagrant abuse of the due process rights of doctors**".

- The recently enacted Emergency Medical Care legislation in the form of House Bill 1415, Act 112 of 1996 requires insurers to reimburse patients or providers for **medically necessary** services provided in a hospital emergency facility due to a "medical emergency". Act 112 appropriately defined the term "medical emergency"; however, the crucial term "medically necessary" remains undefined in the law, and continues to allow managed care organizations or health insurance companies to impose arbitrary denials based on medical necessity definitions in which the insurer's medical director has broad or absolute discretion to make that decision. Thus, Act 112 is a hollow victory for health care consumers *sans* the enactment of an objective definition of the term "medically necessary".

- The Pennsylvania Medical Assistance regulations focus on whether a service is "compensable" under the program; therefore, if the program pays for it, it is necessary. 55 Pa. Code § 1101.21. Again, no objectivity exists. Coverage is **not equivalent** to medical necessity.

Managed Care Organization Contracts

- Most managed care contracts do not define the term "medically necessary".

- Of those that do define the term, the vast majority of MCO contracts with physicians follow the Insurance Department's authority, under which the MCO medical director retains absolute discretion to interpret what treatment is "medically necessary".

- Many other MCO contracts never disclose any definition or criteria to be used, and do not make this information available to the patient or physician, thus creating a disjointed and confusing definition in the minds of patients and providers.

The Criminal Component

- The United States Attorney for the Eastern District of Pennsylvania recently outlined his plans for increased **criminal** prosecutions against physicians seeking reimbursement for care beyond what is medically necessary.

- He also plans to prosecute physicians for not providing enough medically necessary care in managed care contract arrangements.

- The criminal prosecutions are not intended to be brought under the Medicare program; instead, they are planned against physicians under **any commercial insurance plan based on the theory of mail fraud** (18 U.S.C. § 1341).

- The U.S. Attorney stated the following:

  "We've shied away, historically, from medical necessity fraud cases because they were so hard to prove, because we thought it would be a swearing contest between doctors. Now, sophisticated databases exist that can outline the parameters of the given plan's acceptable practice standards. **We see medical necessity as an issue of the future where we will no longer rely on our own experts saying what happened. We will rely on the databases that the hospitals have, the doctors have, and the insurance companies have.**"

(Statement by James G. Sheehan, Assistant U.S. Attorney for the Eastern District of Pennsylvania on November 14, 1995 in remarks to a conference sponsored by the National Health Care Anti-Fraud Association.)

- Incredibly, the federal government believes physicians can be held criminally liable for providing too much or too little care **by looking at statistics** - **even though the term is not defined under state law**!

- This classic "double bind" presents compelling rationale to enact an objective definition of medical necessity as contained in HB 2849.

The Clinical Perspective

In their effort to contain costs, too many insurers have removed much of the individualization that quality health care requires. The human body is not a widget. Each one is not troubled by the same problem, and each has a unique reaction to any given problem. Although general guidelines are appropriate in the practice of medicine, there must be room for flexibility. This flexibility must be tailored to the patient as determined by his or her doctor. The following examples will illustrate this point.

1. Categorization - Although most patients with their first bout of back pain do not need MRI investigation, some do. Patients with severe pain, weakness of the legs or history of cancer must be promptly investigated. Denial of payment in such a case when the study turns out to be normal is common. The stated reason is that MRI is not needed in a first bout of back pain. Blanket categorization leaves little room for individualization, thus creating a potential compromise in quality of care.

2. Unrealistic Expectations - Most patients can be back on their feet and home after a few days in the hospital with a case of pneumonia; however, people who are ill to begin with, not eating well, or lack adequate family support generally do not do so well. Unfortunately, it is not uncommon for an insurer to terminate benefits after a set period whether or not the patient is able to be discharged. Expecting everyone to progress to discharge at the same rate is both unrealistic and creates a potential compromise in quality of care, as well as increased cost of care for re-admissions.

3. The Retrospective Eye - Looking back on a patient's illness, it is often easy to identify services which were unnecessary. It is unfair, however, to be too quick to deny payment for these services without viewing the care **prospectively**. That is, the attending physician is often making a life and death decision based on incomplete information. Any patient with chest pain could potentially be having a heart attack. If the physician wrongly sends the patient home, the consequences can be fatal. It is therefore the standard of care that many patients who turn out to not be having heart attacks are admitted to the hospital. Despite the best science has to offer, such "false alarms" are inevitable. Zealous second guessing by insurers via retrospective "paper review" is inappropriate.

When one has a vested interest and has never seen the patient, it is tempting to retrospectively, categorically and unrealistically determine that a given service was unnecessary. A statutory definition of "medical necessary" as it applies to medical services would further patient care by allowing the physician to focus his treatment on providing what the patient **needs**, rather than what will be **paid for**.

The Legislative Solution

The Medical Necessity Act would:

- Require all health insurance policies and networks to pay for medically necessary care;
- Define "medical necessity" in objective terms;
- Apply the definition to every type of insurance policy or plan including commercial insurance, HMOs, PPOs, the Blues, workers comp, auto, TPAs, provider networks;
- Not apply to a particular type of care if an insurance contract expressly and lawfully excluded that type of care; and
- Permit a physician, hospital or other licensed health care provider to recover compensatory damages, interest at 12% per annum, court costs, attorneys fees and triple damages if bills were not paid when treatment provided satisfied the definition.

Inter-Play with Tort System

- Conflicts between medical ethics and professional liability often arise as a result of the lack of an objective definition of "medical necessity". If an insurance company concludes a service is not medically necessary, and the physician's clinical analysis suggests that it is medically necessary, the physician is faced with an ethical and liability quandary: if the physician provides the care, the physician will not be paid; if the physician abides by the insurance company determination on concurrent review, the physician could be subject to professional liability for failure to provide necessary care. Unknowingly, the patient is caught in the middle.
- A classic example of this "Catch 22" situation arose in litigation in the California Appellate Courts imposing liability on a utilization review organization which dictated premature association of benefits and treatment resulting in the patient's suicide. The Court held as follows:

  "The patient who requires treatment and who is harmed when care which should have been provided is not provided should recover for the injury suffered from all those responsible for the deviation of such care, including, when appropriate, health care payors [and UROs]. Third party payors of health care services can be held **legally accountable when medically inappropriate decision** result in

defects in the design or implementation of cost-containment mechanisms as, for example, when an appeal is made on a patient's behalf for medical or hospital care is arbitrarily ignored or unreasonably disregarded or overwritten. However, **the physician who complies without protest with the limitations imposed by a third party payor, when his medical judgment dictates otherwise, cannot avoid his ultimate responsibility for this patient's care**. He cannot point to the health care payor as the liability scapegoat when the consequences of his own determinative medical decisions go sour."

Wickline v. State of California, 192 Cal. App. 3d 1634, 239 Cal Rptr. 810, 819 (1986).

Source of Definition

- PAFP developed the legislation by analyzing and incorporating provisions from the Medicare statute, regulations and Carriers Manual, as well as case law from various federal and state jurisdictions, ERISA contracts, and most important - common sense and experience.

- PAFP submits along with this testimony a supplemental, extensive memorandum of law detailing the authoritative sources relied upon in development of the definition of "medical necessity".

What HB 2849 Will NOT Do

- It will not create cookbook medicine by proscribing precisely the care that is medically necessary; instead, it provides objective guidelines against which all treatment can be judged for validity.

- It will not create any coverage mandates. In fact, page 2, lines 8 through 11 expressly state that nothing in the act requires an insurance company to pay for any treatment expressly and lawfully excluded by a health insurance policy. The legislation applies only to services covered under an existing policy.

- It will not result in automatic reimbursement for all services rendered by physicians. Under this statutory framework, care that is proven not to satisfy the definition need not be paid.

Conclusion

Insurance company denial of medically necessary care based upon subjective "20/20 hindsight" and "paper reviews" is unfair to patients, health insurance policyholders, physicians and the Commonwealth of Pennsylvania. PAFP respectfully requests that the Judiciary Committee approve this measure and give us the opportunity for a House floor vote. Thank you.